Craig Q. Adams, DMD PA
William B. Cheek, DDS PA

11001 Raven Ridge Rd., Suite 101 • Raleigh, NC 27614 • 919-866-1360

Patient ID # ____________________

PLEASE PRINT

1 PATIENT INFORMATION

Today's Date ____________________

Patient Name ____________________
Last Name

____
First Name Middle Initial Preferred Name

Address ____________________

City ____________________

State ____________ Zip ____________

E-mail ____________________

Driver's License # ____________ State ________

SS # ____________________

Sex ☐ M ☐ F Age _____ Birthdate ____________

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced

Patient Employer/School ____________________

Occupation ____________________

Employer/School Address ____________________

____

Who is responsible for this account? ____________________

Spouse, Parent or Guardian's Name ____________________

Birthdate ____________________

SS# ____________________

Spouse's Employer ____________________

Whom may we thank for referring you? ____________________

2 DENTAL INSURANCE

Subscriber's Name ____________________

Relationship to Patient ____________________

Insurance Co. ____________________

Group # ____________________

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name ____________________

Birthdate ____________ SS# ____________

Relationship to Patient ____________________

Insurance Co. ____________________

Group # ____________________

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with ____________________ and assign directly to Dr. Craig Q. Adams & Dr. William B. Cheek all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentists may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

____
Signature of Patient, Parent, Guardian or Personal Representative

____
Please print name of Patient, Parent, Guardian or Personal Representative

____________ ____________
Date Relationship to Patient

3 PHONE NUMBERS

Home (____) ____________ Work (____) ____________ Ext ____ Cell Phone (____) ____________

Spouse's Work (____) ____________ Best time and place to reach you ____________

IN CASE OF EMERGENCY, CONTACT:

Name ____________________ Relationship ____________________

Home Phone (____) ____________ Work Phone (____) ____________

4 DENTAL HISTORY

Reason for today's visit ____________________

____

Former Dentist ____________________

City/State ____________________

Date of last dental visit ____________________

Date of last dental X-rays ____________________

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Bad Breath ☐ Yes ☐ No
Bleeding Gums ☐ Yes ☐ No
Blisters on lips or mouth ☐ Yes ☐ No

Burning sensation on tongue ☐ Yes ☐ No
Chew on one side of mouth ☐ Yes ☐ No
Dry mouth ☐ Yes ☐ No
Fingernail biting ☐ Yes ☐ No
Food collection between the teeth ☐ Yes ☐ No
Foreign object impaction ☐ Yes ☐ No
Gums swollen or tender ☐ Yes ☐ No
Lip or cheek biting ☐ Yes ☐ No
Loose teeth or broken fillings ☐ Yes ☐ No
Mouth breathing ☐ Yes ☐ No
Mouth pain, brushing ☐ Yes ☐ No
Orthodontic treatment ☐ Yes ☐ No
Sensitivity to cold ☐ Yes ☐ No

Sensitivity to heat ☐ Yes ☐ No
Sensitivity to sweets ☐ Yes ☐ No
Sensitivity when biting ☐ Yes ☐ No
Sores or growths in your mouth ☐ Yes ☐ No
TMD ☐ Yes ☐ No
Pain around ear ☐ Yes ☐ No
Clicking or popping jaw ☐ Yes ☐ No
Jaw pain or tiredness ☐ Yes ☐ No
Grinding teeth ☐ Yes ☐ No

How often do you floss? ____________

How often do you brush? ____________

- OVER -

5 HEALTH HISTORY

Physician's Name & Phone # ______________________ Date of last visit ______________

Have you ever taken any of the group of drugs referred to as "bisphosphonates" related to osteoporosis? These include Fosamax, Boniva, Actonel, Didronel, Reclast, Zometa, and Aclasta. ☐ Yes ☐ No For how long? ______________

Place a mark on "yes" or "no" to indicate if you have had any of the following:

Condition	Yes/No	Condition	Yes/No	Condition	Yes/No
AIDS/HIV	☐ Yes ☐ No	Depression	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No
Artificial Heart Valves	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Date ______________		Fainting or Dizziness	☐ Yes ☐ No	Do you use antibiotic premeds?	☐ Yes ☐ No
Do you use antibiotic premeds?	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Date ______________		Heart Murmur	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Do you use antibiotic premeds?	☐ Yes ☐ No	Heart Problems	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Hepatitis Type ______	☐ Yes ☐ No	Special Diet	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Swollen Feet or Ankles	☐ Yes ☐ No
		Jaundice	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Tonsilitis	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Tumor or growth on head or neck	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No		
Congenital Heart Lesions	☐ Yes ☐ No	Do you use antibiotic premeds?	☐ Yes ☐ No	Ulcer(s)	☐ Yes ☐ No
Cortisone Treatments	☐ Yes ☐ No	Nervous/Anxiety Disorders	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Cough, persistent or bloody	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Weight Loss, unexplained	☐ Yes ☐ No

Do you wear contact lenses? ☐ Yes ☐ No
Do you drink alcoholic beverages? ☐ Yes ☐ No __________ drink(s) per day/wk
Do you smoke cigarettes, pipes or cigars? ☐ Yes ☐ No __________ per day/wk

Women:
Are you pregnant? ☐ Yes ☐ No Due Date ______________ Are you nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

MEDICATIONS

List any medications and supplements you are currently taking and the correlating diagnosis (if you have a list we may attach a copy):

____

____

Pharmacy Name ______________________

Phone (_____)______________________

ALLERGIES

☐ None
☐ Aspirin
☐ Barbiturates (Sleeping pills)
☐ Clindamycin
☐ Codeine
☐ Iodine
☐ Latex
☐ Local Anesthetic
☐ Penicillin
☐ Sulfa
☐ Other ______________

6 CONSENT FOR TREATMENT

1. I hereby authorize Dr. Adams / Dr. Cheek, and/or designated staff to take x-rays, study models, photographs and any other diagnostic aids deemed appropriate to make a thorough diagnosis for (full name of patient) ______________________________'s dental needs.

2. Upon such diagnosis, I authorize Dr. Adams / Dr. Cheek, and/or designated staff to perform all recommended treatment mutually agreed upon by me, including fluoride treatment, and to employ such assistance as required to provide proper care.

3. I understand that this office files my insurance claims as a courtesy. Any claim not paid within 45 days of treatment is my responsibility.

4. Lastly, I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service. A late charge of 1.5% (18 APR) for any balance over 60 days will be assessed to my account.

Signature ______________________________ Date ______________

If other than patient, indicate relationship: ______________________________